KR-300
Rev. 3/08

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH
AND FAMILY SERVICES
Department for Public Health

RADIATION OPERATOR CERTIFICATION APPLICATION FORM

Instructions

Print in ink or type.

Answer each item completely and accurately. Incomplete answers may result in delay of your certification.

FOR DEPT. USE ONLY

DO NOT WRITE IN THIS SPACE

_____

_____

I. PERSONAL INFORMATION

Date of Birth: _____
Month Day Year

Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

_____
Telephone Number

NAME: _____
(Last) (First) (Middle)

MAILING ADDRESS: _____
(Street, Road, or Box No.)

_____
(City) (State) (Zip Code)

II. GENERAL

A. Fees:

Application applying for and fees associated with application.

1. General Certification
   - ☐ Radiography (ARRT)..... $60.00
   - ☐ Nuclear Medicine (ARRT or NMTCB) $60.00
   - ☐ Radiation Therapist (ARRT) $60.00
   - ☐ Radiologist Assistant (ARRT) $60.00
2. Limited Certification
   - ☐ LXMO (Kentucky) $60.00
   - ☐ Podiatry (Kentucky) $60.00
   - ☐ Bone Densitometry (Kentucky)..... $60.00
3. Temporary Certification **(Valid for one year-Not renewable)**
   - ☐ Graduate of an ARRT or NMTCB approved program..... $50.00
   - ☐ Graduate of Limited Radiography Program..... $50.00
   - ☐ Graduate of the Kentucky Independent Limited Program..... $50.00
4. Provisional Certification **(Valid for one year-renewable)**
   - ☐ Nuclear Medicine Alternate Course of Study..... $50.00

   Must provide documentation of progress to renew

MAKE CHECK OR MONEY ORDER PAYABLE TO: THE KENTUCKY STATE TREASURER

B. Have you previously applied for Kentucky radiation operator certification?
(Check appropriate box) ☐ yes ☐ no

If "Yes", When _____

Under what name _____

III. EMPLOYMENT INFORMATION

_____
Work Telephone Number

A. Place of Employment (Name): _____

B. Business Address: _____
(Street, Road, or Box No.)

_____
(City) (State) (Zip Code)

C. Where are you employed? (Check appropriate box)

- ❑ Hospital
- ❑ Clinic
- ❑ Private Office
- ❑ Unemployed
- ❑ Mobile Health Service
- ❑ Other _____

D. Are any radiographic examinations, utilizing contrast media (e.g. gall bladder, GI series, IVP, etc.) performed at your place of employment? ❑ yes ❑ no

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IV. PROFESSIONAL AFFILIATION

A. Are you certified by The American Registry of Radiologic Technologist (ARRT)?
(Check appropriate box) ❑ yes ❑ no

B. If "Yes", submit a copy of the **ARRT registry certificate**.

C. Are you certified by the Nuclear Medicine Technology Certification Board (NMTCB)?
(Check appropriate box) ❑ yes ❑ no

D. If "Yes", submit a copy of the **NMTCB certificate**.

V. EDUCATION INFORMATION

A. Have you graduated from High School? (Check appropriate box) ❑ yes ❑ no
If "Yes", year of graduation _____

B. Have you passed a High School Equivalency Test (GED)?
(Check appropriate box) ❑ yes ❑ no

If "Yes", give Equivalency Certificate Number: _____ Date: _____

C. Indicate the type of teaching facility where you received your training as a radiation operator.
(Check appropriate box)

- ❑ Hospital
- ❑ Vocation/Technical School
- ❑ Junior/Community College
- ❑ University
- ❑ Military
- ❑ Kentucky Limited Independent Study Course
- ❑ Other _____

D. Name and address of the teaching facility at which you received your radiologic technology training:

_____
(Name of teaching facility)

_____
(Address) (City) (State) (Zip Code)

Date of Graduation: _____

E. Have you received a degree from a college/university? (Check appropriate box) ❑ yes ❑ no

If "Yes", check the appropriate box for the highest degree received:

❑ AA/AS ❑ BA/BS ❑ MA/MS ❑ Ph.D.

VI. SIGNATURE/DATE

All applicants please read and sign/date the statement below. All applications will be null and void unless properly signed and dated.

I hereby submit this application and supporting documents and attest to the authenticity and accuracy of the application and all information contained herein. I further understand that if any information contained in this application or supporting documents submitted on my behalf, is determined to be false or misleading, may be cause for denial, revocation or suspension of any certificate pursuant to this application and for criminal prosecution and punishment.

_____ _____

(Signature of Applicant) (Date)

MAIL APPLICATION FORM AND APPROPRIATE FEE TO:

Radiation Operator Certification Program
HS 1 C-A
275 East Main St
Frankfort KY 40621